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ABSTRACT

The study described in this paper illustrates how key features of rhetorical analysis can be operationalized to apply to the study of therapeutic transactions. After a discussion of psychotherapy as an influence process, the paper describes the methodology used in an analysis of tape-recorded discourse between three therapist/client dyads in an attempt to discover whether rhetorical activity transcends particular approaches to therapy. It discusses the rhetorical operations applied to the discourse and presents findings with respect to four rhetorical devices previously shown to discriminate between successful and unsuccessful therapeutic transactions: ethos appeals (in which therapists attempt to increase their perceived expertness, trustworthiness, and attractiveness), logical appeals, tension release mechanisms, and stylistic devices. For each rhetorical device, segments of therapeutic dialogue are presented and discussed to illustrate how the device functions as a rhetorical resource. The paper concludes by noting several values of the study, including its contribution to verification of the hypothesis that rhetorical criticism is useful in the study of therapeutic change; by pointing to needs for further research; and by outlining implications of the study for the training of therapists. (GT)

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A Rhetorical Approach to the Study of Psychotherapeutic Discourse

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A Rhetorical Approach to the Study of Psychotherapeutic Discourse

The expansion of the scope of rhetorical criticism was advocated as early as 1970 by the Committee on the Advancement and Refinement of Rhetorical Criticism.[1] The committee specifically recommended that "rhetorical criticism must broaden its scope to examine the full range of rhetorical transactions."[2] Given the goal of extending the study of rhetoric to include non-traditional areas, we must initially select those which appear to involve influence processes in some fundamental way. An argument could probably be made for the rhetorical nature of every symbolic interaction. However, certain types of discourse, because the content is necessarily highly suasory, appear to warrant the attention of the rhetorical critic as productive areas of investigation. Within the past few years, non-public interpersonal transactions have been examined as situations where persuasion was central to outcome.[3] In analyzing private, everyday discourse, speech

[1]Thomas Sloan, Richard Gregg, Thomas Nilsen, Irving J. Rein, Herbert Simon, Herman G. Stelzer and Donald W. Zacharas, "Report of the Committee on the Advancement and Refinement of Rhetorical Criticism," The Prospect of Rhetoric, ed. Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1971). p. 22

[2]Ibid., p. 225.

[3]See for example, Mark Knapp, Nonverbal Communication in Human Interaction, (New York: Holt, Rinehart and Winston, 1978); Gerald M. Phillips and Nancy J. Metzger, Intimate Communication (Boston: Allyn and Bacon, Inc., 1970); Susan R. Glaser, "Rhetoric and Psychotherapy," Cognition and Clinical Science, ed. Michael J. Mahoney (Plenum Publishing Corp., in press); Susan R. Glaser, "Rhetorical Criticism of Psychotherapeutic Discourse", (Phoenix, Arizona: Western Speech Communication Association Convention, 1977); Susan R. Glaser and Peter A. Glaser, "Rhetorical Criticism of Interpersonal Discourse", (San Francisco, California: Western Speech Convention, 1976); Barbara Scharf, "Grounding a Rhetorical Theory of Marriage Counseling: An Experimental Analysis of Counselor-Client Transactions", (Phoenix, Arizona: Western Speech Communication Association, 1977).

communication scholars have focused on the persuasive elements that affect the outcome of interpersonal episodes.

The purpose of this paper is to expand the scope of rhetorical criticism to include the psychotherapeutic interview, an influence situation identified by its emphasis on the modification of perceptions, attitudes, behaviors. Psychotherapy is an influence process; perhaps it constitutes the most basic persuasive act. Therapists, as certainly as politicians, advertisers, or intimates, are in the business of belief and behavior change. Therapists use the spoken word to alter their clients' thoughts, feelings, behavior in direct, deliberate ways. The therapist's talk is rhetorical because it is a "personalized request for adherence to some proposition or position."[4] Its purpose is to "render the audience different in belief, in attitudes, in feeling, or conduct as a direct result of the discourse.[5] Its basic function is the "use of words by human agents to form attitudes or induce actions in other human agents."[6] It is the "art of motivation...of instilling, activating, or directing in another individual...a belief or a type of conduct."[7] "...it functions ultimately to produce action or a change. It is a mode of altering reality...by the creation

[4]Carroll Arnold, Criticism of Oral Rhetoric (Columbus: Charles E. Merrill Publishing Co., 1974), p. 12.

[5]Robert Oliver, The Psychology of Persuasive Speech (New York: David McKay Co., Inc.), p. 12.

[6]Kenneth Burke, A Rhetoric of Motives (Berkeley: University of California Press, 1969), p. 41.

[7]Oliver, p. 10.

of discourse...introduced into the situation...to bring about the significant modification of a thing which is other than it should be...[8] It contains the strongly practical, deliberate, suasory...instructional qualities that are associated with the 'rhetorical.'"[9]

The psychotherapeutic literature is a quagmire of conflicting procedures and theory.[10] For decades, advocates of varied forms of psychotherapy have argued the effectiveness of their particular method. Despite this effort, no one mode has been demonstrated to be clearly superior at successfully "curing" clients.[11] That all are able to flourish simultaneously despite wide differences in approach suggests that each has something which clients find acceptable and helpful. On the other hand, despite prolonged polemics and proselytizing, no one mode of therapy has demonstrated its superiority. This suggests that there are characteristics common to all types of therapy which probably contribute as much to their effectiveness as the features that differentiate them.[12] If these

[8]Bitzer, pp. 3-4, 4-7.

[9]Arnold, p. 5.

[10]See, for example, Raymond Corsini, Ed. Current Psychotherapies. (Itasce, Illinois: F.E. Peacock Publishers, Inc., 1973); Jerome Frank, Persuasion and Healing. (Baltimore: The Johns Hopkins University Press, 1973).

[11]Phobias are the exception to this statement, responding more promptly to behavioral techniques. However, phobias represent only 3 percent of the people seeking psychotherapy. (Frank, 1973, p. 313).

[12]Ibid,. p. 23.

common characteristics are rhetorical processes, it may be possible to uncover some major components of therapist potency which until now have remained elusive.

Much of what happens in the therapeutic transaction is shaped by the interactions between client and therapist.[13] This makes the therapeutic situation a rhetorical event in which the psychotherapist assumes the burden of change agent. If change inducing talk is somewhere important in therapy transactions, it becomes critical to find out where it occurs, and how and what its characteristics are and ought to be. Influence processes, then, may be viewed as fundamental to the process of therapy. Clients enter therapy because they are distressed about some aspect of their behavior, thoughts, feelings. The therapist as helper is expected to lead the client to change. In order to facilitate this change, the therapist must influence the client to behave, think, feel differently. Regardless of therapeutic mode, therapists sometimes succeed in this influencing and sometimes they fail. There are times when clients accept the therapist's directives, suggestions, assignments, language, reframing of events, analysis of past history. But there are times when they do not. It is this critical element of the therapeutic chain that speech communication scholars can help to explain.

The psychotherapeutic literature implicitly confirms the role of therapist as change agent. Freud was probably the first to recognize the relationship between persuasion and therapy.[14] As we review how more current psychotherapeutic writers define and describe their profession, it becomes apparent that there are increasing numbers who view therapy primarily as an influence process in which therapists engage in verbal maneuvers designed to achieve a desired

[13]Henry L. Lennard and Arnold Berstein, The Anatomy of Psychotherapy: Success of Communication and Expectation (New York: Columbia University Press, 1960).

[14]Gene M. Abroms, "Persuasion in Psychotherapy," American Journal of Psychiatry 124:9 (March 1978).

end state from a given beginning state.[15] There has been an increased emphasis on the procedures by which therapeutic change occurs and on how influence processes can be most effectively utilized to promote client change.[16]

These psychotherapeutic positions, then, support Frank's contention that what is shared by therapists may be as therapeutic as what is unique, the common element being persuasion. Now we must consider the structure and content of these persuasive elements, for it is not particularly relevant to call psychotherapy an influence process unless we can explicate particular therapist acts that are influential. It is here that a large body of rhetorical literature may provide direction and focus. If rhetorical components are discovered in divergent modes of therapy, we may agree with Frank that "features common to all types of psychotherapy probably contribute as much, if not more, to their effectiveness than the characteristics that differentiate them...any specific healing effects of different methods would be overshadowed by therapeutically potent ingredients shared by all."[17]

[15] See, for example, John Gillis, "The Therapist as Manipulator", Psychology Today, (December, 1974), p. 92; Stanley R. Strong and Ronald Matross, "Change Processes in Counseling and Psychotherapy", Research Bulletin, 12 (University of Minnesota, December 15, 1971), p. 20.

[16] See, for example, Jay Haley, Strategies of Psychotherapy (New York: Grune and Stratton, 1963), pp. 2, 16, 137-149; Paul Watzlawick, J. Weakland, and R. Fisch, Change: Principle of Problem Formation and Problem Resolution (New York: W.W. Norton and Co., Inc., 1974), p. xvi.

[17] Frank, pp.2, 23.

Data Analysis I: Development of the Methodology

The critical question now becomes: What is the most fruitful approach to studying the rhetorical characteristics of therapist-client transactions? Since the purpose of this investigation was to discover whether rhetorical activity transcends particular approaches to therapy, an attempt was made to explore a variety of (a) forms of therapy and (b) types of problems presented by clients. To indicate how many different conceptual positions were represented in the study, each participating therapist was asked to respond to the following question:

> Which five psychotherapeutic authorities have provided the greatest influence on your therapeutic approach? Please rank order your responses.

Following are the responses received:

Therapist I:
- Albert Bandura
- B.F. Skinner
- Gerald C. Davison
- Albert Ellis
- Marvin R. Goldfried

Therapist II:
- Fritz Perls
- Barry Stevens
- John Enright
- Jim Simkin
- Carl Rogers

Therapist III:
- C.R. Rogers
- H.S. Sullivan
- S. Freud
- C. Ferster
- J. Wolpe

If the range of responses had been narrow, any common rhetorical tendencies in therapeutic discourse would have had to be considered bound to specific theories or techniques. However, the diversity of responses received from the three therapists suggests that they do, indeed, differ in theoretical and philosophical perspectives. Therefore, if rhetorical strategies are found to occur consistently among the therapists analyzed, we may be confident that these tendencies are not specifically bound to certain theories and procedures.

The data in this study consist of dialogue: 11 hours of tape-recorded discourse between three therapist-client dyads. Each of these therapist-client pairs was taped during the first three sessions of therapy, and each session lasted approximately 75 minutes. The discourse was initially analyzed by applying nine rhetorical operations described by Arnold and developed initially for the examination ar i analysis of explicit and implicit meanings in extended public discourse. These operations constitute an attempt to discover the "suggestive potentialities" of what is said. They help a critic to "uncover what discourse does or does not have the power to do."[18] This procedure for rhetorical criticism was chosen because of its utility in a similar study examining dialogue between intimate partners.[19] Each of the nine analytical procedures is listed below in question form.

[18] Carroll C. Arnold, Criticism of Oral Rhetoric. (Columbus: Charles E. Merrill Publishing Co., 1974), p. 70.

[19] Susan R. Glaser and Peter A. Glaser, "Rhetorical Criticism of Interpersonal Discourse." Western Speech Communication Association Convention: San Francisco, California, 1976.

1. From analysis of client patterns of verbal imagery, what are the prominent therapeutic exigences? What is possible, allowable, invited by clients in the communication with their therapists?[20]

2. What are the simplest interpretations the client could put on the therapist's words? Are these interpretations likely to satisfy the prominent therapeutic exigences?[21]

3. What is likely to be perceived as explicit claim making by the client? Was sufficient "argument" provided given what is known about this particular client and the demands of this therapeutic situation?[22]

4. What solutions are offered by the therapist for the client's problems and anxieties? Does the therapist provide or lead the client to discover ways of alleviating, managing, tensions and anxieties?[23]

5. Are the items essential to the therapist's purpose given special claim on the client's attention by their context, specifically through the use of juxtaposition, analogy, suggested continuity, and figure-ground discrimination?[24]

[20] Carroll C. Arnold, Criticism of Oral Rhetoric. (Columbus: Charles E. Merrill Publishing Co., 1974), p. 30.

[21] Ibid., p. 71.

[22] Ibid., pp. 62-63.

[23] Ibid., p. 76.

[24] Ibid., pp. 79-84.

6. Are the therapist's explicit and implicit claims likely to be viewed as compatible by the client?[25]

7. Are the kinds of responses encouraged by the therapist (factual, optative, adjudicative, predictive of desirebility) likely to lead to a resolution of exigences that exist in the therapeutic situation?[26]

8. What does the therapist say to heighten ethos--to increase the likelihood of being perceived as credible by the client?[27]

9. Does the style of the therapist's talk intensify its content, specifically through the use of balance, antithesis, metaphor, sensory images?[28]

[25] Ibid., p. 85.

[26] Ibid., pp. 89-95.

[27] Ibid., p. 97.

[28] Ibid., pp. 168-69.

Data Analysis II: Reliability of Findings

Although the results of applying the preceeding operations were carefully argued and appeared reasonable to the author, the question still remained: Would other researchers make the same judgments? To begin answering this question, the author conducted a graduate seminar in "Therapeutic Rhetoric" in which five graduate students were taught how to apply these principles of rheterical criticism to the therapeutic situation. After spending 10 weeks rhetorically analyzing tapes of diverse therapy sessions, each student was given the dialogue initially analyzed by the author. The students analyzed this therapeutic discourse independently, performing seven of the nine rhetorical operations described above. The questions concerning contextual aids and compatible claims were omitted during the course of the term as they were discovered to provide little new information. For two of the remaining seven operations there was a wide range of responses from the critics. Specifically, there was little consensus regarding (a) the definition of therapeutic exigences and (b) the nature of responses encourged. Therefore, although theoretically and conceptually these two operations may be important in explaining a therapist's rhetorical activity, they still require further refinement and will not be reported on in this paper. Similarly, the question concerning "simplest interpretations" was necessarily omitted because of its direct relation to the issue of therapeutic exigences. Based on the independent analysis of six critics, then, what follows is a discussion of "therapist rhetorical potency," defined theoretically as "the capacity of therapist discourse to influence." The framework offered should be viewed as tentative hypotheses generated from rhetorical theory, designed to objectify acts that could be influential in therapeutic transactions. The purpose is to operationalize those therapist behaviors that affect client change. The next step will be to test whether therapists engaging in these acts are consistently more influential than those who do not. Table I provides a description and illustration of each rhetorical

device discussed below. The discourse offered to clarify each rhetorical operation should be viewed as an illustration of the concept -- not as empirical evidence.

Insert Table I About Here

Therapist rhetorical potency appears in all probability to be multidimensional in nature, depending, at least in part, on the extent of the following four devices: 1) ethos appeals; 2) logical appeals; 3) tension release mechanisms; 4) stylistic forms. Although these four rhetorical resources clearly do not represent or exhaust the rhetorical strategies available to therapists, they were chosen as an approach for discovering what goes on in therapy for several reasons. First, they have been shown to discriminate between successful and unsuccessful therapeutic transactions. In addition, they can and have been translated into therapist intervention behaviors. Finally, they have been applied reliably by six independent critics. Each of these rhetorical operations will not be discussed. First, each concept will be operationalized, then specific segments of therapeutic dialogue will be presented to illustrate how the device functions as a rhetorical resource.[29]

Ethos Appeals

Ethos was originally described by Aristotle as the most potent means of persuasion:

> The character (ethos) of the speaker is a cause of persuasion when the speech is so uttered as to make him worthy of belief; for as a rule we trust men of probity more...we might almost

[29]The analyses performed in this paper will be published in Psychotherapy Process: Current Issues and Future Directions. Michael J. Mahoney, ed. (Plenum Publishing Corporation, in press).

> affirm that his character (ethos) is the most potent of all the means of persuasion...the sources of our trust in (speakers) are three...intelligence, character and good will...the speaker who is thought to have all these qualities has the confidence of his hearers.[30]

The findings from a series of investigations concerning therapy as an influence process help us to delineate three components of therapist ethos strikingly similar to those Aristotle described: perceived expertness, trustworthiness, and attractiveness. Strong defines expertness as the "perception of a communicator as a source of valid assertions."[31] He contends that this perception is influenced by "(a) objective evidence of specialized training, such as diplomas, certificates, and titles, (b) behavioral evidence of expertness, such as rational and knowledgeable arguments and confidence in presentation, and (c) reputation as an 'expert.'"[32]

Strong and Matross argue that therapists can increase their perceived expertness by certain behaviors, such as referring to specific areas of expertise. For example, they suggest that a therapist can begin an attempt at influence with, "I have dealt with this problem many times and in my therapy experience it means..."[33] Torrey suggests that the naming process

[30]Aristotle, The Rhetoric, ed. Lane Cooper (New York: Appleton-Century, Croft, Inc., 1960), pp. 5-9, 91-92.

[31]Stanley R. Strong, "Counseling: An Interpersonal Influence Process," Journal of Counseling Psychology, 15 (1968), pp. 215-224.

[32]Ibid., p. 216

[33]Strong and Matross, p. 19.

is another means by which therapists are able to offer behavioral evidence of their expertness:

> The very act of naming (what is wrong with the client) has a therapeutic effect. The patient's anxiety is decreased by the knowledge that a respected and trusted therapist understands what is wrong.[34]

Schmidt and Strong, after studying perceived expertness in therapists, report the following behaviors as indicative of expertise:

> The expert...treats (the client) as an equal...asks direct and to the point questions...moves quickly to the root of the problem...points out the contradictions and suggests possible solutions.[35]

A second component of therapist ethos is perceived trustworthiness which, Strong concludes, affects the extent to which the therapist is able to influence opinion in the client.[36] Frank contends that certain attitudes of therapists must be communicated to the client if trust is to be established. These include "...a steady, deep interest, an optimistic outlook, and a dedication to the patient's welfare" in addition to the assurance of confidentiality, which tells the client there are no selfish or devious motives involved.[37]

[34]Fuller E. Torrey, The Mind Game, Witchdoctors and Psychiatrists (New York: Bantam Books, 1973), p. 16.

[35]D. Lyle Schmidt and Stanley Strong, "Expert and Inexpert Counselors," Journal of Counseling Psychology, 17 (1970), pp. 115-118.

[36]Strong, p. 219.

[37]Ibid., p. 222.

Based on the research of Strong and his associates, the third component of therapist ethos appears to be perceived attractiveness. "A communicator's attractiveness is based on his perceived similarity to, compatibility with, and liking for the influence recipient."[38] Perceived similarity is often associated with interpersonal attraction,[39] and interpersonal attraction increases the acceptance of influence.[40] Strong and Matross contend that if therapist and client discover strong similarities in world views, the client is more likely to "adopt therapist interpretations, attitudes, and reactions..."[41] Strong argues that when counselors communicate their understanding of a client, even if it is derived from theoretical knowledge, such understanding is likely to enhance the client's perception of similarity and compatibility with that therapist.[42] Based on this discussion of therapist ethos, this rhetorical variable may be operationalized by eight different behaviors that a therapist might perform. It is contended that if therapists behave in any of the following ways, their

[38]Ibid., p. 216.

[39]Ellen Berschied and Elaine Walster, Interpersonal Attraction (Reading, Massachusetts: Addison-Wesley, 1969); Schmidt and Strong, 1970.

[40]Timothy C. Brock, "Communicator Recipient Similarities and Decision Change," Journal of Personality and Social Psychology, I (1965), pp. 650-68; Stanley R. Strong and David Dixon, "Expertness, Attractiveness and Influence in Counseling," Journal of Counseling Psychology, 12, (1972)

[41]Strong and Matross, p. 10.

[42]Strong, p. 222.

ethos is likely to be enhanced:

1) Therapists may directly refer to their own expertise and experience in a given matter.
2) Therapists may indirectly demonstrate their expertise by labelling or naming what is wrong with the client.
3) Therapists may make recommendations and suggest possible solutions.
4) Therapists may communicate an interest and concern for the client's welfare as well as an optimistic outlook.
5) Therapists may assure clients of confidentiality.
6) Therapists may reveal values, opinions, experiences which they share with the client.
7) Therapists may communicate understanding of the client.
8) Therapists may communicate high esteem for the client.

In the following segments of therapeutic discourse, the therapist's talk has the potential to heighten his ethos in a number of ways.

T: It sounds to me that your head is very well together in terms of the way you're looking at this...You're not shitting on yourself and saying, "I'm responsible for what happened with _____." I like the way you're handling it by saying, "I'm going to take a breather from this relationship and I'm not going to make any commitments or plans for what I do within the the next week or month." On the other hand your perception of yourself--speaking as professional to professional for a minute--is not atypical. In the last 5 or 6 years I would say about 30 to 40 percent of the clients that I see present situations where...well if you run down the characteristics which in our culture theoretically should make you an ecstatic person, you're in the upper 10 percent of the distribution

in almost everything: you're in good physical condition, you're obviously intelligent, physically attractive, you don't have any trouble attracting the opposite sex, you're successful in athletics, you've been successful in school, prestigious occupation. Yet, in spite of the fact that from someone else's perspective you seem to have everything going for you and you have no reason to feel badly about yourself or complain about your life situation, your perception of yourself is quite a bit different than that. Even though at a cognitive level, at a rational level, you can agree to all this; you can say, "Yes, I'm in good physical shape. I'm intelligent. I'm attractive. I'm good in athletics. I'm a talented professional"...even though you can give these relatively rational responses, at a gut level you still feel relatively insecure about yourself. Judging from some of the research in the clinical field there are some common themes running through this: One of perfection striving. One of the reasons you have been good as an athlete and in your profession is that you seek perfection. You don't just want to be better than the group, you want to give it everything you've got and be as good as is humanly possible. That obviously has advantages. If I'm undergoing surgery that's the kind of surgeon I'd want. The problems that arise are when those standards start to carry over to your evaluation of yourself.

First there is considerable talk about this therapist's professionalism, his knowledge, and his ability as a therapist. In lines 7-10, for example, the implicit message is: I have been doing therapy for a long time; I have had many clients; I can spot trends. Lines 26-28 point to his familiarity with the research of his field. Thus, on several occasions, the therapist has provided an opportunity to heighten his <u>ethos</u> with talk that explicitly suggests

he is a competent and experienced professional. Another opportunity for credibility enhancement by this therapist is provided by talk which suggests his high esteem for the client. Lines 10-16, for example, indicate this positive regard. In addition, on several occasions the implicit message of the therapist's words is: You're moving in a positive direction and that is something to be proud of.

248 T: I can't believe the movement you've shown in the short period
249 of time already... You're a therapist's dream in terms of a
250 client...in terms of being very much into what you're thinking
251 and wher you're going...Are you aware of how differently
252 you're coming across now than three or four weeks ago?
253 C: I feel different.
254 T: I wish I had saved the tapes so that you could listen to your-
255 self or see yourself...That's very different from the way
256 you were coming across then.

Although this talk is not directly aimed at heightening the therapist's professional image it has the capacity to raise his ethos by communicating high esteem for the client as well as an optimistic outlook.

Logical Appeals

This variable focuses on what Aristotle called logos, the content or logical argument of speech. Toulmin offers a perspective which clarifies how we may estimate the potential strength of a given argument:

> A man who makes an assertion puts forward a claim - a claim on our attention and to our belief...its merits depend on the merits of the argument which could be produced in its support...We can, that is, demand an argument; and a claim need be conceded only if the argument which can be produced in

its support proves to be up to standard.[43]

The notion of argument seems particularly relevant to client-therapist transactions. Because of the nature and purpose of psychotherapy, clients in all likelihood perceive the therapist's talk as intended to change them in some way. Strong and Matross define "influence attempts" in therapy as: "Therapist remarks which the client perceives to imply that he change his actions, feelings, or thoughts.[44] Arnold's adaptation of Toulmin's formulations provides insight to and clarification of the audience as judge of arguments.

> The respondent perceives the utterance as one meant to modify his experience. He knows he has the right to challenge if the grounds for claims seem perplexing or insufficient. He functions as judge on questions of relevance, significance, and sufficiency.[45]

The persuasiveness of reasoned argument is confirmed by studies conducted by Brehm and Lipsher.[46] They examined the effects of providing supporting reasons in general attempts to persuade and discovered that communication accompanied by supporting arguments was more likely to result in opinion change than

[43]Stephen Toulmin, The Uses of Argument (New York: Cambridge University Press, 1958), pp. 11-12.

[44]Strong and Matross, p. 8.

[45]Arnold, p. 49.

[46]Brehm and Lipsher, "Communicator - Communicatee Discrepancy and Perceived Communicator Trustworthiness," Journal of Personality, 27 (1959), 350-361.

communication without support. But what, exactly, does it mean to "support a therapeutic argument?" Most simply, it refers to the provision of evidence which makes therapist claims appear more reasonable. In analyzing therapist discourse, the following may be considered to be evidence of support:

1) Supporting examples are presented. These examples may be drawn from past and present client behaviors, other relevant cases, other persons' behaviors.
2) Statistics are presented. Therapists may provide numerical evidence to support claims.
3) Citations from authority are presented. Therapists may quote relevant authorities or professional literature.
4) Analogies are presented. Therapists may support claims through comparisons. Analogies often compare a present to past behavior, client behavior to other behavior.

Examining Therapist I's discourse in lines 6-33 on pages 15-16, the claim appears to be: Your problems arise from perfection striving, setting standards that are unrealistically high. The likelihood of the client's accepting this claim is increased by the large amount of evidence offered to answer the client's possible question: "What have you got to go on?" In fact, most of the 27 lines of talk provides evidence encouraging acceptance of the major claim. The evidence consists of examples, statistics, and authority references. The following evidence is provided to indicate perfection striving in the client's life:

Statistics:

You're in the upper 10 percent of the distribution in almost everything.

Examples:

Good physical condition; obviously intelligent; physically attractive; don't have trouble attracting the

opposite sex; successful in athletics; successful in school; prestigious occupation.

YET, ON A GUT LEVEL YOU STILL FEEL RELATIVELY INSECURE.

The warrant for accepting the therapist's general claim is implicit:

If a person has so much going for him and still feels insecure, it is reasonable to believe his standards are too high.

To make the client's acceptance of this claim even more likely, the therapist offers statistics and authority as further support. The extensive use of numbers and percentages adds to the scientific sound of the therapist's evidence.

Statistics:

In the last 5 or 6 years, 30-40 percent of the clients I see present similar problems.

Authority:

Judging from some of the research in the clinical field... there is a theme of perfection striving running through this.

The implication appears to be: According to scientific research, perfection striving is a real problem, and the date don't lie.

Tension Release Mechanisms

This variable appears especially important in therapeutic discourse, for one of the main reasons a client enters into a therapeutic situation is to achieve relief from tension and anxiety. Arnold emphasizes the importance of tension release mechanisms:

> The degree that problems are vivified and anxieties intensified, tension-releasing solutions must come from somewhere, else communication ends in producing unfocused feeling and/or general frustration. Generally speaking, failure to give clear directions for releasing tensions is a faulty rhetorical practice.[47]

[47]Arnold, p. 77

This is not intended to suggest that it is incumbent upon a therapist to provide solutions to every problem a client generates. It does mean, however, that when a problem is vivified -- either by the client or therapist -- ways of alleviating it need to be located, either directly or indirectly. It is the case in therapeutic situations, as in general rhetorical situations, that: "Only where situational or other data assure a critic that frustration or vague euphoria was aimed at, or that tension release mechanisms were clearly known to the listeners, should he (a critic) suppose non-releasing rhetoric fulfilled its aim.[48] In therapeutic transactions we may consider any of the following to be tension release mechanisms:

1) Discourse which describes the client's situation as being hopeful, solvable.
2) Discourse which reconceptualizes the client's problem in more manageable, less traumatic terms.
3) Discourse which suggests that change is already taking place, progress is being made.
4) Discourse which offers direct solutions.

Examining Therapist I's discourse in lines 6-34 on pages 15-16, it is clear that a problem is vivified by him. The implicit message from the therapist seems to be:

> You are feeling anxious and tense because you seek perfection;
> unless you modify your standards of self-judgment,
> you will continue to feel insecure. (See lines 6-34 on pages 15-16).

The question now becomes: If the client accepts these problem claims, is he offered a way out of the accompanying anxiety and tension?

After spending considerable time vivifying the problem of perfection striving, the therapist concludes by offering his client a release from that

[48] Ibid., p. 77.

tension by describing the client's situation as hopeful, solvable, and by reconceptualizing the client's problems in more manageable, less traumatic terms:

67 and I guess one of the reasons I enjoy talking to you...not only
68 because I like you, but because I've had some experiences that par-
69 allel yours, partly in terms of the perfectionism...about how I
70 feel about myself...I've had to work on that...I've had
71 to work a lot on how I feel about me...what my standards are
72 ...I share the physical fitness thing...And I guess one
73 of the things that was most important in my feeling good about me
74 was when I realized...I was always waiting for the day when I would
75 wake up and say: "I'm there. I've got my shit together." And the
76 thing that was most missing from me was something that will come
77 across is a lot in my speculations with you and that is that you never
78 arrive...you never get there...And it's the realization
79 that you never get there that's getting there. It's always a jour-
80 ney rather than a destination. You never hear the whistle and say,
81 "This is the stop." Because you're always moving...always
82 rolling with the punches. I think that part of the empty feeling
83 that I had and some of what's coming across as part of the
84 feeling that's missing is that you haven't gotten anyone either
85 from the outside or the inside to say, "You're there. You've
86 arrived." And I think it's going to have tremendous benefits to
87 you when you realize that you're never going to get set...that
88 you're never going to arrive...And so it's not playing the
89 game to win, it's playing the game to stay in.

In this segment, the therapist discloses that he, too, had problems and anxieties similar to those of the client, which he has been able to resolve. This has the potential to provide some release from tension. Further release is offered in lines 73-79. Here, the therapist offers his client a new way

of conceptualizing his problems and anxieties. If the client accepts the notion that "you never arrive, because life is a journey and not a destination," he cannot feel as anxious about "not getting there". Thus, the therapist first vivifies a problem of perfection seeking, and then offers his client several avenues leading to tension release.

Stylistic Devices

In examining this component of therapist rhetorical potency, we shall be looking for the extent of balances, antitheses, metaphors, sensory images and their capacity to intensify the content of therapist discourse. Although these four components of communicative style have not been empirically tested, each of them does have normative acceptance in rhetorical theory.[49] Balances refer to verbal patterns which put ideas in pairs, in a series, or in other parallel constructions. Rhetorical critics argue that these balanced groupings have the capacity to make what is said seem more completely true, important, impressive. Antitheses, although usually balanced in some way, involve ideas that are asserted to be marked by their contrast or opposition with each other. By emphasizing differences and by suggesting conflict, antithetical constructions argue that the contrast or conflict suggested linguistically is actually true in fact. Metaphors are stylistic devices in which a term or phrase is applied to something to which it is not literally applicable, in order to influence the listener to perceive a resemblance. Based on the lore of ancient and modern rhetorical theory, it is contended that unless metaphors are confusing, distasteful, or hackneyed, they are likely to make communication appear more interesting and colorful, as well as to argue in favor of the relationships they portray.[50] For the last of these assertions there is considerable modern,

[49] Ibid., pp. 168-169.

[50] Ibid., p. 168.

theoretical argument and some empirical evidence.[51] Sensory images are all words and phrases that direct listeners to think of anything they could feel, hear, taste, smell, or see. Presumably, sensory images encourage listeners to experience messages vicariously; to the extent that this occurs, listeners are more likely to become personally, experientially involved in the speaker's message.[52]

In conducting an analysis of speakers' styles, the verbal forms described above are pulled out of their context and listed by the class. To illustrate the use of stylistic analysis, let us examine Therapist II as she attempts to convince her client that her fear of being perceived as "uptight" is a function of her Berkeley peer group, among whom "uptight" behavior is considered a severe violation of norms. The therapist attempts to convince her client that human feelings are different from theoretical principles and that any feeling is legitimate -- including feelings that might be labelled "uptight" by the Berkeley group. The client's response to this discourse indicates her verbal acceptance of the therapist's message: "I think I would. Yeah...I do...ooh. I hadn't ever thought of it...right...yeah, it's true...right. Yeah." An examination of the therapist's stylistic devices shows us that choice of language was a rhetorical resource available to the therapist which may have contributed to the client's verbal indication of belief change. Following are lines of therapist discourse from which stylistic features were compiled.

[51] John Bowers and Michael Osborn, "Attitudinal Effects of Selected Types of Concluding Metaphors in Persuasive Speeches", Speech Monographs, 33 (June, 1966) pp. 147-155.

[52] Arnold, p. 183.

I: My guess is that it would be a heavy attack on you because of what looks like a substitution of Berkeley for your family. Is that ...

C: Explain that.

I: In needing a family you used Berkeley as a family. And so it's very important for you to live up to their principles, just as it is to somebody who is still very attached to their family to live up to their family principles.

C: Uh.

I: And one of those principles is not being uptight. Right? (Laughter). It's probably A #1 principle is 'We are liberal. We are not uptight'. And to be accused of being "uptight" is to be accused of being a traitor to your clan.

C: Ooh. I hadn't ever thought of it.

I: This is a basic accusation that is very, very hard to handle when it hits at: that's the thing that makes me a part of the group that is most important to me. Mine is a group where people are not uptight, where they are liberal and can stand nonnuclear families and can look at life in broader terms and can be loving, and you know, all those things are part of that, a, that folklore that makes your group a group. So, when you are attacked on that, it's like attacking a Christian on his belief in Christ.

C: Right. In fact, we call it our mythology. (Client laughs.)

I: Yeah. Right.

C: And there's that kind of 'this is ridiculous but'. Yeah, it's true.

I: And the difficulty is that human feelings are human feelings whether you happen to believe in being liberated or in being a

243 Christian or whatever you happen to believe in. You know if
244 you are jealous, you are jealous, and if you're feeling re-
245 jected, you're feeling rejected.
246 C: Right. Yeah.

Balances

to be accused of being...is to be accused of being...
human feelings are human feelings
happen to believe in ... happen to believe in
and can stand...and can look...and can be...
if you are jealous, you are jealous
if you're feeling rejected, you're feeling rejected

Antitheses

where people are not uptight...where they are liberal
we are liberal, we are not uptight
whether you... believe in being liberated or in
being a Christian or whatever...

Metaphors

attached to their family
very hard to handle
look at life
attacking a Christian
traitor to your clan
it hits at...the thing that makes me a part
you are attacked

Sensory Images

call you a lot of things

needing a family

accused of being uptight

feeling jealous

heavy attack

accused of being a traitor

a group where people are not uptight

being loving

feeling rejected

Although in an initial analysis of a speaker's style, it is first useful to pull verbal forms out of context and list them by class, it is then important to gain a more holistic understanding of style as a rhetorical resource. In the discourse analyzed above, the therapist's use of balance, antithesis, metaphor, sensory images do have the capacity to intensify the content of her talk. Let us now consider more specifically how this is accomplished. The balanced constructions are likely to make the ideas appear more "sweepingly true," "impressive," "important."[53] They also have the capacity to make the therapist seem more "logical" to her client. The content of the array of balanced constructions is striking; each balance contributes to the impact of one of three therapeutic messages:

1) You have substituted Berkeley for your family.
2) Being perceived as uptight is extremely difficult for you to handle because it goes against one of Berkeley's most important principles.

[53]Ibid., p. 168.

3) Human feelings are all legitimate -- even if they are indications of being 'uptight.'

The therapist also employs antithesis to argue by emphasizing contrasts. By contrasting "We are liberal" with "We are not uptight" the therapist emphasizes the extremes of the Berkeley philosophy and the implicit impact these contrasting ideas have had on her client's values. The therapist also employs antithesis as she attempts to convince her client that any feeling is legitimate, even though it may be perceived as less than liberal on the Berkeley hierarchy of values. By focusing the client's attention on contrasting belief systems (Whether you happen to believe in being liberated or in being a Christian or whatever, you happen to believe in..."), the therapist is able to emphasize her residual message: Even in diverse belief systems, human feelings are human feelings -- they are always legitimate. In short, by setting ideas against each other in antithetical constructions, the therapist increases the likelihood that she will influence her client.

The therapist's abundant metaphors, in addition to adding color and interest, also seem to function argumentatively. Most bring into figure a message of: It is because you have substituted Berkely for your family that you find it difficult to handle being perceived as uptight. Thus, the metaphors, like the balances and antitheses, focus on a prominent therapeutic message. The possibility of the client becoming "experientially hence feelingly" involved in the therapist's talk is enhanced with the abundance of sensory images.[54] In addition, these sensory images appear to work together to alter the client's feelings toward "uptight" behavior. "Uptight" images are contrasted with "liberated" images thereby serving as an antithesis-generated argument. Once more a stylistic device focuses the client on Berkeley's hierarchy of values as the source of her distress. The therapist's sensory images also have the capacity to evoke and sustain

[54]Ibid., pp. 168-169.

feelings and impressions which are vital to the therapist's argument. This examination of style, then, illustrates how the therapist's use of balance, antithesis, metaphor, sensory images represents a rhetorical resource with the capacity to focus client attention on ideas central to the therapeutic message, and to make those ideas appear more legitimate and believable.

Limitations and Conclusions

The goal of this investigation was not to produce generalizations about therapeutic outcome, but rather, to illustrate how key features of rhetorical analysis can be operationalized to apply to the study of therapeutic transactions. The purpose of the study was neither to look for obvious uniqueness among therapists nor to evaluate the rhetorical effectiveness of different therapeutic schools. The purpose was to search for and identify consistent uses of rhetorical strategies discernible in distinctly different forms of therapy. Our primary concern was to develop and test a methodology and to uncover hypotheses. The general purpose of the study was to discover whether rhetorical criticism could be fruitfully applied to psychotherapeutic transactions of differing kinds. The therapists whose work was examined do not constitute a representative "sample" of therapeutic dyads. Nor is it being argued that the therapists were randomly selected and were in that sense "representative." The purpose here was to discover whether rhetorical activities transcend particular approaches to therapy.

Although this kind of investigation prohibits broad generalizations, it is a test of a potentially useful way of describing the behavior of therapists engaged in modifying the behavior, thoughts, feelings of clients. Herein lies the study's utility; it is an attempt to analyze the content of therapist verbal behavior as rhetoric in process. Despite the small number of therapists analyzed, this study constitutes a step toward verification of the hypothesis that

rhetorical criticism is useful in the study of therapeutic change. With it demonstrated that rhetorical activity is fundamental to therapeutic practice, we are now in a position to begin exploring the relationships of various rhetorical strategies, or lack of them, to outcomes. The opportunity is present, then, for the therapist to ask questions before the fact much as the critic does after the fact. We already do this in public speaking situations; there is no reason to believe it cannot be done in private therapeutic transactions.

The four components of therapist rhetorical potency described in this paper can be stated as hypotheses which can be further operationalized and tested. Toward this end, coding procedures could be developed which reliably discriminate rhetorical acts. Such coding procedures have been developed in other contexts, and there is no reason to assume that they could not be developed for this purpose.[55] In addition, outcome studies could be conducted to clarify the relative contributions of specific rhetorical acts to change in client behavior. In order for such outcome studies to proceed, however, we must first define therapeutic influence, what a client might do or say to indicate that a therapeutic effect has been produced. So far we have been examining independent variables -- those behaviors a therapist might engage in to influence clients. Before an outcome study can be undertaken, the dependent variable, therapeutic change, must be further delineated. Given that "mental health" as an abstraction is not a particularly helpful measure of therapeutic outcome, we must further specify those ways in which a client can be affected, changed by a therapist. Shall we look for changes made within the therapeutic hour, compliance with a treatment regimen, changes in problematic behavior occurring outside the therapy session, verbal acceptance of therapist directives, change in relationships with others, changes in self-talk? Before we can more fully understand the relationship between

[55]Hyman Hops, Thomas Wills, Gerald Patterson and Robert Weiss, Marital Interaction Coding System, University of Oregon, 1971

therapist talk and client change, we must first delineate specific independant variables and their effects on specific dependent variables. As indices of therapeutic outcome, we must first explicate and evaluate specific client behaviors and avoid global measures of psychological functioning.[56]

Our call for a more scientific approach to the study of therapeutic change must be sounded with caution, however. Although our explanation and prediction of central therapeutic influence behaviors may become increasingly scientific, in the end an artistic judgment must always be rendered as the therapist selects the available means of persuasion for every given case. That is the nature of a rhetorical situation. The four rhetorical resources described in this paper - ethos appeals, logical appeals, tension release mechanisms, stylistic devices - are not presented as laws to be applied unconditionally across clients, but rather as alternative influence strategies to be selected among for a particular client - audience. In attempting to discover what might constitute appropriate therapeutic discourse, the therapist must first analyze the client to whom the discourse is to be directed to discover what the person's perceptual world would find fitting.

Obviously, not all therapeutic rhetorical behaviors will be effective for all clients. One might legitimately argue, for example, that providing definitive interpretations of client behavior is less effective than tentative ones, or that offering evidence is inappropriate and unnecessary. Our point is that the ultimate judge of therapeutic rhetoric is the client, and rhetorical resources must always be adapted for the particular client - audience. In the end, deploying rhetoric means making an artistic judgment.

This study does have important implications for training therapists. It appears that training procedures which teach only the specific content of one therapeutic approach are severely limited. Considerable emphasis should be placed on the structure and strategy by which a therapeutic message is delivered. Regardless of method, it appears that students of therapy would profit from an

[56]Anthony Biglan and David Kass, "The Empirical Nature of Behavior Therapies," Behaviorism 5 (1977).

understanding of the rhetorical resources available to them. We may now be able to teach neophyte therapists a method for discovering the nature of their therapeutic situation in any given case, and what their rhetorical resources are within that situation. The utility of such an emphasis is strongly implied by Mahoney.

> "We have devoted invaluable human skills and material resources in efforts to change beliefs about the relative merits of deodorants and political candidates. Meanwhile, our clinics, hospitals, and homes are inhabited by individuals whose existence and daily well-being are painfully jeopardized by dysfunctional beliefs...Had we devoted as much time and concerted research effort toward refining the techniques of therapeutic belief change as we have invested in marketing research, the pervasiveness of contemporary thought disorders might have been dramatically reduced. Needless to say, our priorities are in need of reexamination."[57]

Critically examining the persuasive components of psychotherapeutic transactions may reveal why and how therapy succeeds and fails, thereby allowing therapists to maximize the occurence and maintenance of therapeutic improvement, and allowing speech communication scholars to better understand the processes by which individuals are persuaded by other individuals. Therapists would gain access to a body of literature in rhetoric and communication theory with the potential for improving therapeutic effectiveness. Speech communication scholars, by studying the theory and procedures of psychotherapy, could receive insight into the process by which behavior, thoughts, feelings are changed or modified through talk.

[57]Michael J. Mahoney, Cognition and Behavior Modification (Massachusetts: Ballinger Publishing Co., 1974), p. 238.

TABLE I

Rhetorical Resource	Rhetorical Resource Operationalized	Example of Rhetorical Resource
Ethos appeals	Therapists may directly refer to their own expertise and experience in a given matter.	I'm what's generally called eclectic; I'm going to try and find out what really is at issue with you and then, with you, try to find the best means to alleviate that situation. And if that means employing analytic notions or rational emotive therapy or some form of desensitization, I could do that.
	Therapists may indirectly demonstrate their expertise by labelling or naming what is wrong with the client	There are some common themes running through this -- one of perfection striving.
	Therapists may make recommendations and suggest possible solutions.	I think you're setting it up to be easy for Bob to play this game...by being so cooperative about it... he doesn't really have to make a choice as long as you're quite willing to go down there with him and to get out of the way when he wants to be with Barbie ...that makes it easy for him not to have to make any decisions.
	Therapists may communicate an interest and concern for the client's welfare as well as an optimistic outlook.	It sounds to me like your head is very well together in terms of the way you're looking at this. I like the way you're handling it.
	Therapists may assure clients of confidentiality.	I want you to know that anything you say here in our sessions is completely confidential.
	Therapists may reveal values, opinions, experiences which they share with the client.	One of the reasons I enjoy talking to you...not only because I like you, but because I've had some experiences that parallel yours, partly in terms of the perfectionism...and I share the physical fitness thing.
	Therapists may communicate understanding of the client.	She could call you a lot of things, but I suspect that "uptight" and "selfish" would be the two that would totally rack you up. You would sit there for hours worrying about whether this was the case.
	Therapists may communicate high esteem for the client.	If you run down the characteristics which in our culture theoretically should make you an ecstatic person, you're in the upper 10% of the distribution in almost everything.

TABLE (contd)

Rhetorical Resource	Rhetorical Resource Operationalized	Example of Rhetorical Resource
Logical appeals	Supporting examples are presented: these examples may be drawn from past and present client behaviors, other relevant cases, other persons' behaviors.	You're in the upper 10% of the distribution in almost everything: you're in good physical condition, obviously intelligent, physically attractive, you don't have any trouble attracting the opposite sex, you're successful in athletics, you've been successful in school, prestigious occupation.
	Statistics are presented: therapists may provide numerical evidence to support claims.	In the last 5 or 6 years, 30-40% of the clients that I see present similar problems.
	Citations from authority are presented: therapists may quote relevant authorities or professional literature.	Judging from some of the research in the clinical field
	Analogies are presented: therapists may support claims through comparisons; analogies often compare present to past behavior, client behavior to other behavior.	So when you're attacked on that belief it's like attacking a Christian on his belief in Christ.
Tension release mechanisms	Discourse describes the client's situation as being hopeful, solvable.	...And again all of that is a reflection of the kinds of standards you set which is something we can work on if you want to.
	Discourse reconceptualizes the client's problem in more manageable, less traumatic terms.	You never arrive...you never get there...and it's the realization that you never get there that's getting there; it's always a journey rather than a destination; and I think it's going to have tremendous benefits to you when you realize that you're never going to get there...that you're never going to arrive.
	Discourse suggests that change is already taking place, progress is being made.	I can't believe the movement you've shown in the short period of time already...you're a therapist's dream in terms of a client...I think that's a sign of...partly in terms of independence and partly that you're willing now to look at some things that in the past were taboo to even consider.

TABLE I (cont'd)

Rhetorical Resource	Rhetorical Resource Operationalized	Example of Rhetorical Resource
Tension release mechanisms (cont'd)	Discourse offers direct solutions.	It seems that in terms of where to go from here, an important exercise or thing to do would be to monitor on a daily basis what's going through your head and to decide whether, number 1: if life continues like it did last week, would you be happy with it or, number 2: if you would not be happy with it, is it because there's something missing that you wish were there or is it because there's something present that you wish weren't?
Stylistic devices	Balances refer to verbal patterns which put ideas in pairs, in a series, or in other parallel constructions.	If you are jealous, you are jealous, and if you're feeling rejected, you're feeling rejected.
	Antitheses involve ideas that are marked by their contrast or opposition with each other.	We are liberal; we are not uptight.
	Metaphors are stylistic devices in which a term or phrase is applied to something to which it is not literally applicable.	To be accused of being "uptight" is to be accused of being a traitor to your clan.
	Sensory images are all words and phrases that direct listeners to think of anything they could feel, hear, taste, smell, or see.	Good physical condition; undergoing surgery; somebody said, "gee, this is terrific!" feeling jealous.